COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

February 8-9, 2000
Sheraton Inn, New Bern, North Carolina

MEMBERS	**February 8-9, 2000**
Emily Moore, Chairman	
Lou Grubb Adkins	
Lois Batton	
Dr. Manjusri Chatterjee	Excused
Joe Coulter	
Dorothy Crawford	
Mansfield Elmore	Excused
Jeanne Fenner	
Pearl Finch	
Albert Fleet Fisher	
Patricia Gill-Gather	Excused
Ken Gerrard	
Dr. Paul Gulley	
George Jones	
Judy Lewis	Excused
Martha Macon	Excused
Martha Y.Martinat	
Floyd McCullouch	
Pender McElroy	
Tom Palmer	Excused
Raymond Reddrick	
Mokie Stancil	
Freddie Turner Stell	
Dr. Bruce Whitaker	

Commission Staff Present
Dr. J Iverson Riddle, Director
Dr. Walter W. Stelle, Deputy Director
Michelle Cotton, Legislative Liaison
Marilyn Brothers, Program Specialist, Regulatory Branch
Charlotte Hall, Rulemaking Coordinator, Director's Office

OTHERS PRESENT – November 8-9, 1999
Sam Stell, Carteret County Commissioner
Roy P. Wilson, Area Director, Neuse Center

Don Willis, Chief, MH Services Section, DMH/DD/SAS
Diane Pomper, A.G.'s Office
Mark O'Donnell, Child & Family Services, DMH/DD/SAS
Charles Franklin, Director, Albemarle MH Program
Linda Watkins, Tideland Area Program
Dan Searcy, Johnston Area Program
Tom Miriello, Cumberland Area Program
Bill Condron, Wayne Area Program
Tara Larson, Asst. Director, DMH/DD/SAS
Charles Davis, Asst. Director, DMH/DD/SAS
James Osberg, DMH/DD/SAS
John L. Crawford, Advocate
Lois Reddrick, Pitt County Area Program
Dr. Philip Veenhuis, Medical Director, DMH/DD/SAS
Mary Eldridge, Access & Quality Section, DMH/DD/SAS
June Cummings, Lenoir Area Program
Clients from the Neuse Center
Jann Harris, DMH/DD/SAS
Ann Schwindaman, NC Council of Area Programs
Charles Franklin, Albemarle Area Program
Jerry Lyall, Director, OBerry Center

Monday, February 8, 2000

Call to Order
Emily Moore, Chairman of the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services, called the meeting to order and delivered the invocation.

Approval of Minutes
A motion was made and seconded to approve the Minutes from the November, 1999 meeting.

Mrs. Moore acknowledged absentee members, Martha Macon due to a conflict, Wymene Valand's recent illness, the death of Tom Palmer's mother, Dr. Chatterjee being out of the country, and Mansfield Elmore's jury duty.

Mrs. Moore recognized Dr. Iverson Riddle, the new Division Director.

Remarks/Dr. Iverson Riddle
Dr. Riddle provided personal background information. He explained that Dr. Bruton recruited him for the Director position, and that the reason for accepting the position is based on his commitment to the people with special needs.

Dr. Riddle explained that his father told him at a very young age that he would be a physician one day. At about age 11, he visited Broughton Hospital where his father served on the old "Board." Dr. Riddle's father introduced him to a "Miss Mack," a laboratory technician, and asked her to raise him because he would be a physician one day. Every time there was an opportunity throughout his school years, Dr. Riddle worked at Broughton Hospital.

Dr. Eugene Hargrove was one of Dr. Riddle's preceptors in psychiatry, and upon completion of training, he served in the military. Dr. Hargrove told him as he was leaving one day, that a school was going to be built in Morganton, and he suggested that upon his return, Dr. Riddle might want to check it out.

Dr. Riddle rotated through pediatric neurology and attended the first medical Congress on mental retardation in 1959. His special interest was children who were impaired. He explained that he also

came under the wing of John Umstead, who shamed the General Assembly one day, into delaying spending $5 million on their building, but rather to use it for building Western Carolina Center.

He acknowledged others including Mrs. Mary Scott, Governor Kerr Scott's wife, her son, Governor Bob Scott, Senator Royal, and more recently, Senator Ollie Harris. Dr. Riddle grew up with people who were very much advocates for the mental health cause.

Dr. Riddle explained that his major reason for accepting the Director position was to make every effort to preserve the area system of services, because without it, services cannot be delivered in North Carolina. He referred to the newspaper articles regarding mental health, and stated that even though the publicity was bad, it has put mental health before the general public. The only time mental health has been remembered is when someone in government needed money.

Western Carolina Center and O'Berry Hospital became ICF/MR certified approximately the same time. The two facilities are about the same size, with almost the same amounts returned to the General Fund, totaling just about $100 million. More recently, Caswell and Murdoch have become certified, and those facilities are much larger than Western and O'Berry. Approximately $100 to $125 million that came from the federal government to help clients has been returned to the General Fund. It makes some people in Raleigh angry when Dr. Riddle states these things, however, he reiterated that he is not running for office. If he were a member of the General Assembly, he would issue a moratorium from taking any money from the Division of Mental Health, and if any money is shifted in it, let it be shifted to where it should be used in the first place.

Dr. Riddle explained that his main concern in mental health is child mental health. Last year, North Carolina attempted to serve 76,000 children; however, services were not provided to 84,000 children.

Dr. Riddle performs a private child psychiatry practice on Saturday mornings, which he has been doing for the past 40 years. He has also worked in a mental health clinic on Thursday evenings for the past 30 years, has been a consultant to a Willie M. program for 15 years, and has worked in a Prison on Sunday mornings for 24 years. He stated that the reason for the high-rise prison in Morganton is filled with young men (624) is because they did not get mental health services, and they will still be unable to receive mental health services when they are released from prison. He explained further that you could send one of those young men to Duke University for what it costs to maintain one in prison for years and years.

Dr. Riddle explained that even though the Willie M. lawsuit is over, he believes that more and more children are being placed into that diagnostic category or class than at the time of the suit.

He believes that children should never be seen in daytime "funny farms," but rather in their natural environment, in public schools. Clinicians should be walking up and down the halls with teachers and conversing with children in a much more natural environment. The General Assembly must find the money somewhere even if it means borrowing.

Dr. Riddle reported that it is a very fragile population that we serve, that generally speaking those who end up in mental health clinics suffer from depression and could be dangerous to themselves or others. This population is usually in bad physical health.

Dr. Riddle explained that a citizen's property shall not be taken from him without due process, and that neither shall a State take away a citizen's property without due process. A person's Medicaid entitlement is his property in legal terms.

Marilyn Brothers informed the Members that the issues under the section Request for Temporary Rule.

John Womble explained that the DEA (Drug Enforcement Administration) on January 27, 2000, DEA issued a final rule for a drug called Monatin which is used in the treatment of narcolepsy and another

product was issued on September 15, zelfion, which is used for insomia. These drugs were scheduled by DEA in Schedule 4 in placement Schedule 4 and we are asking the Commission to schedule them likewise and place them in the Commission Rules as Schedule 4. As a result of Commission action last year, two other things need to be changed. One is in the phrase 45G .0308, Use of Synthetic Canavanoids in Schedule 2. Sister navanole was rescheduled in Schedule 3. Schedule 2 is not applicable, so that needs to be dropped and we recommend that the Use of Synthetic Canavanoid be the lead-in phrase. The other lead-in phrase dealt with is 45H .0203 b1, the phrase Debain Deriot Retorphinol needs to be deleted entirely.

Marilyn Brothers stated that we would be asking the approval of the Commission on Tuesday to proceed with the procedure of rulemaking for a temporary rule.

Ms. Brothers announced that Pete Martin, the Head of the Criminal Justice Branch with DMHDDSAS, Substance Abuse Services will be bringing to the Commission rules pertaining to DWI laws and introduced Mr. Martin. He informed us that each year 70-80,000 people were arrested while driving impaired. Annually between 50-60,000 people are convicted. The hard core driving drinker is the one group that is the hardest to impact on. Usually he is the uneducated white male 21-34 year old who doesn't drink anymore than his friends do and they all drive 3,000 pound weapons. We are one of the few states that have clinically based diagnostic criteria in place. All of our placements are through the American Society of Addiction Medicine, the ASAM placement criteria. Thanks to Representative Martha Alexander, we have had that in place since the last 5 or 6 years. One other thing is that we have been evaluating what we have been doing since 1980. Tom Miriello was the Chief of Substance Abuse Services in 1980 and we contracted with the UNC Safety Highway Research Center in Chapel Hill. The cost was $31,000 a year. In 1995, they followed 109,000 people for two years. They found that the people who came in got our assessments, who completed and paid for the treatment that was recommended, the recidivism after two years was 74% less than the ones who did not. As a condition of suspended sentence every convicted person is required to come to one of our providers whether they be public or one of the 280 privately licensed substance abuse facilities and get an assessment, as a condition of probation. Even more important, if they ever want to drive legally in this state or any other, they have to complete, pay for, and we have to through our office, notify DMV that that has happened before they can ever be reinstated to drive their vehicles again. Another thing we have done is we have replicated the study from 1995. In October of 1998, the Research Center followed an additional 20,000 people that had been convicted in the first 6 months of 1996. They again concluded that the people who complied, their recidivism rate was 4% over a two-year period and those who failed to comply, their recidivism rate was 2 ½ times or 11% for another DWI charge. In January 1998, we entered into a Memorandum of Agreement with Division of Facility Services to do a 2 hour site review at every facility prior to their licensing and their relicensing. We are also sending information to facilities to help them get started in a more positive manner, the law, the rules, etc. Not only can we help them deal with their addiction, but also we can help keep our highways safer than in the past. In 1994, all the providers at the Commission got up and spoke in favor of rules. They wanted structure. Over and above licensure, we need to come up with a privileging system. We need to have quality care services for our population. I hope to bring back in May. I am passing out an article "Drunk, Dangerous and Deadly." We need to try to intervene with rehabilitation.

Mrs. Moore announced that she had several articles to pass out from the Charlotte Observer. Tony asked that we pass out this request from him to me that he would like the Commission to act on after he presents his program this afternoon. Also, is a picture of John and Dorothy Crawford who were honored in January 16 by the Daughters of the American Revolution for their Community Service Award and they will be going next week to receive the state honor in that. Mrs. Moore had written a letter from the Commission and as a friend, being a part of that.

A packet from Dr. Riddle from the Western Carolina Center and the report of Selective Services from Pat Porter is also information that is available to the Commission members.

Mrs. Moore announced that the dinner for the Commission and Staff will be held at the East Carolina Yacht Club at 6:00. The buffet lunch will be held in the City Side Café in the hotel.

Mrs. Moore introduced the State Auditor Ralph Campbell. She asked where the Commission fit in the Study. Mr. Campbell answered by saying that he will include that with his program later in the presentation. Mr. Campbell announced that Grant Blair with Public Consulting Group, Incorporated (PCG) to go over the problems to be solved and the issues for consideration that have been identified in the Study. The desire of Mr. Campbell and the wishes of the General Assembly are for the outcome of the Study to become a blueprint for the delivery of mental health services in the State of North Carolina. The Office of the State Auditor was directed to coordinate the Study to be done in two phases. Phase I was to update the April 19, 1998 MGT Study on the State's Psychiatric Hospitals. Phase II, the major part of the Study was to examine the Area Programs and the mental health service delivery system. PCG began work on February 1, 1999 on both Phase I and Phase II. As we began to plan for the study, we realized that we needed someone on our team with the direct knowledge and expertise with the intricacies of the mental health delivery system. The Office of the State Auditor entered into a technical assistance contract with the North Carolina Institute of Medicine in Chapel Hill. Personnel from the Institute provided the State Auditor's Office with advice from the very beginning of the Study, to include the development of the request for proposals or requests for bids. As work began, questions began to arise as to whether the PCG Study would address the issues of having a separate division for Developmental Disabilities Section. The legislation did not specifically require this and the time the PCG Study started, Price Waterhouse Cooper was in the process of examining that issue along with the issues related to other Department of Health and Human Services programs. Therefore, the original RFP that PCG responded to did not include DD specifically. After considerable discussion with the Department of Health and Human Services and Dr. Bruton, we made the decision to have PCG specifically address this issue. In July, Phase I was expanded to include the questions of whether DD should be a separate division. The overall structure of the mental health delivery system has not changed significantly since the early 1970s. The Department of Health and Human Services and the Division have undertaken a number of studies of components of the system. To this point, no study has been conducted on the overall system. Additionally, the Department of Health and Human Services and the Division have a number of changes and initiatives in process. These include the redesign plan, planning for utilization management, discussions on DD redesign, and recently a reorganizational plan for the Division. Secretary Bruton agrees that the State Auditor PCG Study is the main study underway on the mental health delivery system in North Carolina. The changes could and most likely will affect other parts of the system. All stakeholders agree that there is a pressing need to have a true continual of services among state, local and private providers. But there has been no clear consensus on how to achieve that continuum. This is where PCG comes in. PCG is examining specific organization, structural and operational issues surrounding state level responsibility and local capacity to provide the needed services. The State Auditor's Office is committed to preserving to objectivity of the Study. Our goal for this Study is to develop a blueprint for the future. We don't want to assign blame for past failures. We want to make sure that the Study concentrates on what works while identifying what doesn't. Our staff has worked hard to establish and maintain open lines of communication throughout the Study. We are in frequent contact with the Department of Health and Human Services, the Division, with the Legislative Staff and Legislators to ensure continued cooperation and coordination of all of our efforts. An additional goal of the State Auditor is to provide an avenue for involvement of all stakeholders in the Study. This will include the NC Mental Health Commission. My staff has met with various professional staff and advocacy groups from the beginning of the Study. We have given updates much like this one to various interested parties as the Study has progressed, as well as the Legislature. The Office of the State Auditor has conducted regional public to allow public interested parties to have input into the change that was desired or needed within the system. These meetings were held in eight different locations across North Carolina during June, July and August of 1999. We also sponsored an expert's panel discussion on other state's experiences in changing their mental health service delivery system and organizing and delivering DD services. We plan to continue this level of openness as the plan progresses. Brant will briefly discuss first the Interim report on the State Psychiatric Hospitals submitted to you and to the General Assembly on May 1, 1999. And secondly, the progress to date on Phase II of the Study. The Interim Report on the Psychiatric Hospitals confirmed the

basic recommendations contained in the May 1989 MGT report. It also gave more complete data on the cost associated with renovating or either new construction. Because it was an interim report, it did not contain firm recommendations on the number or types of hospital beds needed. Nor did it address the proper locations of the hospitals. It did however identify further procedures that are being developed during Phase II of the Study. To fully address some of the remaining questions about the hospitals, PCG is now working on a detailed analysis of admissions and discharge data. The legislation requires that the final report on this Study be submitted by December 1, 1999. However, to provide a better report for the entire service delivery system, we requested and received permission from the General Assembly to delay the final report until April 1, 2000. We have expanded the scope to include a step to connect the psychiatric hospital recommendations to the service delivery recommendations. This piece of the final report will make it a much better blueprint for providing a true continuum of care. This portion of the Study will be completed and included in the final report for Phase II. PCG is diligently working on Phase II which addresses the overall service delivery system including the DD issues. PCG has completed a tremendous amount of work since the Study began February. We are still on track as well as PCG in delivering this Study to the General Assembly on April 1, 2000, just a few short days from now. The work that we have done with PCG has been most exciting. PCG brings to the table a great deal of expertise, not only in consulting work for government organizations, but also specifically in the mental health delivery field. They are based in Boston, have office in Charlotte as well as other locations. They have done studies in at least 20 other states on the mental health delivery system, and probably an additional 20 local government operations in the mental health delivery system.

Mr. Campbell introduced Mr. Grant Blair, from the PCG Charlotte Office.

Notes from the Overheads explained by Grant Blair

Services

Looked at understanding services, gaps and impact on hospital problems

1) Wide variability in accessibility, quality of clinical assessment
2) Services for acute SA lacking statewide leading to use state hospitals as the default tax setting
3) Role of state hospitals unclear and varies across state. State hospital gate keeping and community placement is ineffective
4) Populations with special needs are frequently undeserved including dual diagnosis, children/adolescents, and elderly.
5) With the demise of CA and end of WM, children services is experiencing major crisis in confidence and direction

Criteria to Meet

1) Enforceable service and tax standards in place that can be met
2) Tax role and function should be consistent and function with the service coordination of area programs.
3) Area programs should have sufficient service and resources to meet base requirements

Ideas

1) Establish clinical assessment standard available 365-days/2 ½ hrs. Spanning all clinical populations.
2) Establish basic benefit package that can be accessed by an eligible client in acute need anywhere in NC
3) Establish and enforce benefit package that can be delivered for target populations
4) SA services should be statewide development priority
5) State hospitals should be defined and staffed as specialty & extended care environments for intermediate and texturing care partnerships should be developed to transfer acute care to community settings.
6) New plan to children's services should be developed by are programs under leadership of DMH/DD/SAS. Plan should be include interagency collaboration and funding

Problems to Be Solved

1. Financial accountability and governance are not closely aligned.
2. There is inconsistency, confusion and suspicion concerning the role of Area programs as brokers and purchasers vs. providers. Area programs/Advocates are cynical and lack confidence that

DMA.DMH will work together effectively to promote policies and financing to support community services. Pas struggles to achieve sufficient management capacity at a reasonable price.
3. Criteria
4. Governance and finance should be aligned
5. Clear and consistent rationale of Area programs. There may be criteria and process for exception
6. DMA / DMH should publicly concern on joint financial and management strategy
7. Area programs. must meet basic financial; management criteria at a reasonable cost
8. Area programs. Should be encouraged to choose their own local partners to build the necessary management capacity and appropriate service boundaries.

Ideas for Consideration

1) Establish process to encourage counties to assume APS responsibilities with state
2) Allow counties to manage AP responsibilities within county government or establish AP management. Entities (APME)
3) Require publicly appointed behavioral health advisory boards to participating
4) Encourage counties to establish APMEs that have sufficient management and services capacity, are cost effective and meet state contracts requirements (10-20)
5) Service network should be maintained locally with multi-county services available to all.

III. Finance and Operations

Financial and operation capacity varies
Significant variation in way Area programs. are financed from 20.02 per capital 42.84
Lost trust in financial capacity
Cynical about DMA / DMH
Minimal cost to Area programs. for using state hospital creates perverse incentives

Criteria

1. Confidence in financial management should be restored
2. DMH / DMA coordinated role and responsibilities
3. Cost of state hospitals
4. Financing and operational improvement should support DMH standards

IDEAS

1. Allocate state funds to Area programs. for core programs
2. Develop allocation methodology to equitability distribute a percentage of projected savings
3. Create start up financing strategy that matches new state to county dollars
4. Require Area programs. to pay for use of state hospitals; create financial incentives for low users and penalties for high users
5. Develop a matching process between state funds and local funds for target populations, including MH.SA clients
6. Establish Area programs. as honest brokers providing assessments developing service plans and providing case management
7. Bolster provider's financial stability and cash flow by allowing them to bill Medicaid directly for services, eliminating Area programs. as fiscal intermediacy. Keep Area programs. as local contracting management with agency.
8. Develop MOU directly between DMA / DMH Area programs. clearly outlining roles.
9. Implement detailed administrative requirements and fiscal monitoring for Area programs. (cost reporting, financial reporting, services reporting) there will be used as criteria in the AP procurement process with counties and / or Area Programs.

Questions and Answer session between the audience and Mr. Campbell and Mr. Blair. Comments from the members include: What is the current relationship between DMA and DMH? What will be the role of the Commission? How does the Commission fit in?

Tony Mulvihill, Executive Director of the Alcohol and Drug Council of North Carolina reported on the strategic planning completed by the group. He is requesting support by the Commission. Commission members will act on the request at the May meeting.

Mrs. Moore also thanked staff and everyone who attended.

The meeting was adjourned for the day.

Tuesday, February 9, 2000

Ms. Moore reconvened the meeting and introduced Roy Wilson. She thanked him for the fellowship and hosting the dinner for members on Monday night. Roy Wilson, Area Director, Neuse Center recognized members of the Neuse Center ClubHouse. The club members presented their program and discussed what the service had offered them and how it had assisted them.

June Cummings, Area Director, Lenoir Center presented on behalf of several area programs in the east on "Hope after Floyd." This presentation explained what has occurred through financial assistance and the role of area programs in assisting their communities after the Hurricane and flooding.

Mrs. Moore expressed concern regarding the Commission's current role. She also explained that Southeastern Regional requested a declaratory ruling from the Commission on the performance audit. Diane Pomper, from the A.G.'s office, has been asked to respond to this issue.

- What is the status of the MI/SA group (the former CAPAC)?
- How can everyone be kept in the loop during these fast-moving times in the Division and State?
- How can the Commission be kept abreast of what is going on? It does not seem possible, meeting only four times a year, and particularly if you do not serve on an area board or receive information other than that received at the scheduled quarterly meetings.
- What information is available to the Commission for determining how Medicaid dollars can be returned from the General Fund back to mental health? The State is running bridges, roads, buildings on mental health dollars (the DSH money).
- What is the current working relationship with DMA; has it improved or gotten worse?
- When can area programs expect to receive final budget allocations? When can they expect to receive the Thomas S. allocations, and other things that are missing? We're already almost in the fourth quarter; when will these issues be resolved? Area program mental health centers cannot operate without those dollars.

Mrs. Moore recognized Judy Lewis, Commission member, who recommended that a letter regarding mental health monies being put into the General Fund be forwarded to legislators. What can be done by members of the Commission for MHDDSAS to impact that? Discussion followed regarding mental health money being reverted to the General Fund.

The question of whether the PCG studied the issue of money earned by the disability sections being reverted back to the General Fund, with all of the needs out in the communities. It appears that would be a very strong recommendation from the PCG report. Tara Larson, Assistant Director for Quality Assurance and Management, explained that the PCG is reviewing all of the financial structure and funding sources. The PCG's financial analysis has been very impressive with all of the data points with everything that is being reviewed. The PCG has a national reputation for doing that sort of work. Final results are not in. There have been some preliminary discussions about costing of hospitals and costing of services, and their impressions of the financial structure. More information should be available within approximately two weeks. Ms. Larson stated that she and Charles Davis would be reviewing some of the initial numbers with Grant (one of the PCG consultants), to make sure that they

are on the right track, and that their numbers are not out of line with what is expected by the Division. This is something the group does as part of their final recommendation. After PCG gives its April report, the Division will be allowed to respond, and in that regard, if the Commission has specific issues, those can be addressed at that time.

Jeanne Fenner, Commission member, asked if Ms. Larson would address the issue of the reversion of over-realized receipts in the psychiatric hospitals and MR centers. Ms. Larson responded that they would. She also explained that PCG is looking at DISH, over-realized receipts, etc. Another inquiry regarding Price Waterhouse doing that same sort of thing, and Ms. Larson stated that they had, in fact, stopped doing that, and that Price… had not had the same depth as PCG.

Charles Davis explained that DSH is not a new issue; that for many years the State has received DISH funds from the federal government as a result of the State providing services to a number of Medicaid-eligible lower income individuals in the State's psychiatric hospitals. The attitude of the General Assembly and the State budget office has been that that money is coming to the State and can be used for any purpose. He further explained that the point made by the Commission is one that will be made to PCG and one that he would like to make to the legislature at any given opportunity. That point is that that money was earned by providing mental health services, and that there are many others who need mental health services, and that money needs to be in the mental health system. He stated that that is a point that will need to be made over and over again, and encouraged members to contact their legislators and reiterate that point. Ms. Finch requested an explanation of DSH. Mr. Davis responded that DSH is defined as disproportionate share and that it means a system by which the federal government reimburses either State or private hospitals that take a disproportionate share of low-income people into their hospitals. Therefore, every hospital in the country that serves a large proportion of Medicaid-eligible or low-income people (which means the hospitals take a loss by that), then those hospitals receive disproportionate share money from the federal government in return for that work. The Division earns that money in the psychiatric hospitals because they are the high providers of Medicaid mental health programs to the Medicaid-eligible population. Again, the State legislature and budget office definitely considers the DSH money to be extra revenue to the State and feel that it can be budgeted in any way. Legally, that is possible; however, the Division feels that on principle that money should be mental health money and should remain in the mental health system.

Dr. Stelle stated that during his tenure as hospital director at Dix, around '92 or '93, total revenues in his budget were $150 million and total expenditures were $55 million. In that one year, approximately $100 million went back to the General Fund.

Judy Lewis made a motion that a letter is sent from the Commission to the State legislators making them more aware of this issue, and that a copy also be sent the State Auditor's Office and the PCG and the State Budget Office. Discussion followed, which included a statement from Dorothy Crawford in order follow political protocol. It was determined that the letter be directed to the Governor and the other parties copied. Mrs. Moore recommended that the letter be as strong as possible. The motion passed unanimously. Tom Miriello, Director of Cumberland Area Mental Health Center, returned to the meeting and explained that he had been in touch with Senator Tony Rand's office. He had informed Senator Rand's assistant that funds ($6.6 million initially slotted for the renovation of the Legislative Office Building, but was deferred to put money back into community health services in a Bill sponsored by Senator Rand) had not been released to area programs. Senator Rand responded by thanking Mr. Miriello and stated that he would check into the matter and would keep Mr. Miriello posted; that he was not aware that the money was being withheld. Mr. Miriello told Senator Rand that he thought either the Department or the State Budget office was withholding the money. Charles Davis was asked to respond. He explained that he was not sure of the exact type of money or the details. At this time, Michelle Cotton, Legislative Liaison, intervened and explained that the language in the Bill, that the Committee approved, did not include that funds be specific to mhddsa services. The funds would be used to prevent services from being cut throughout the entire Department of Health and Human Services. However, Coalition 2001 lobbied and campaigned extremely hard and received from Senator

Rand the support that they needed to make that decision to find the money. The language is such that the Secretary has the discretion to use the funds in any of his agencies in DHHS, since the language in the Bill does not specify that the funds must be used for mhddsa services, even though that was the intent. Charles Davis explained that the official notice on this Bill had not been received, but was expected. Mrs. Moore thanked Tom Miriello.

Pearl Finch, member, asked if there was available data for the PCG study on the area programs' budgets and the amount of money that county commissioners contribute to each of the budgets. Dr. Stelle responded that the Division maintains that data on an annual basis, and that the PCG has received that data. Ms. Finch addressed a statement made by Roy Wilson, Neuse area director, which encouraged the Commission to continue what it had been doing; Ms. Finch asked exactly what that was, and if he had any recommendations to enhance, improve, and make the Commission's role stronger. She expressed concern on behalf of the Commission that members feel some of their power has been usurped by degree, and that the Commission would like to reclaim it. Mr. Wilson explained that "wiping out the myth" would be one way to do that. He clarified that he heard the myth perpetuated during the Mental Health Study Commission meeting; area programs are bad managers and that there was the issue of fraud and abuse. That may have happened in one or two, out of at that time, 41 area programs. That is not typical and does not generally happen within the area program system. It is unfair for programs, which are properly run to be punished because of two or three badly, run programs. At the Council board meeting last month, this issue was discussed, and it appears that programs get brandied by the worst.

Ms. Finch said that she had recommended going after only those programs that are failing to run "their show" properly, not the entire lot. The response she received was that the area authority controls area programs. Roy Wilson explained that if the Division Director were to appear before his area board and stated that Neuse was being improperly operated, then Roy Wilson would be gone.

Martha Martinat was recognized and referred back to the four PCG solutions presented earlier: 1) fix the system; 2) place area programs directly under the State; 3) privatize; and 4) county commissioner solution. She recommended that the Commission vote on each of those to determine on which this body agrees should be the solution; subsequently, have the results conveyed to the proper authority. Floyd McCullouch seconded the recommendation (intended to be a motion). Discussion followed

Ms. Larson explained that what was presented on the previous day was the PCG's initial impression, that this may or may not be the final recommendations written in the April 1 report. When the report is released in April, the Division will need to respond in some fashion. The response and the report will then go to the Legislative Study Commission and to whatever body that will review the results.

Michelle Cotton explained that the State Auditor and PCG is not mandated by the legislation to present to the Legislative Study Commission, but has chosen to do so out of courtesy and being good political players. She further recommended that the Commission for MHDDSAS, as a rulemaking body, requests that simultaneously with the State Auditor and PCG's results presented to the Legislative Study Commission, that they also present to this Commission.

Staff explained that, when appropriate, the Commission for MHDDSAS might hold special meetings.

Dr. Al Fisher, member recommended that the Commission take a position opposing what appeared to be PCG's current stance, the County Commissioner solution.

Tom Miriello, Area Director, Cumberland, explained that the number one recommendation under governance from the PCG is to eliminate the statutory-base creating area boards.

Ken Gerrard, member, reiterated Dr. Fisher's recommendation that the Commission take a position opposing what appeared to be the PCG's County Commissioner's solution.

Mrs. Moore acknowledged Martha Martinat's withdrawal of her previous motion.

Pender McElroy, Commission attorney and member, was asked to legally and properly assist in stating the motion. He stated that the motion was to have the Chairman of the Commission direct a letter to the State Auditor and the PCG requesting that the sense of the Commission for MHDDSAS would be opposed to any report that would eliminate area mental health authorities and citizen input that comes from that by placing the responsibility with county commissioners. It was also stated to ensure proper copying to Dr. Riddle, etc.

Charles Franklin, Area Director, Albemarle Mental Health, suggested that the letter be presented in conjunction with one of their opportunities for public input at one of the Study Commission meetings.

Dr. Bruce Whitaker, member, explained that a question was raised regarding "fix the problem," and that approximately three or four years ago, the NC Council embarked on a mission to begin something similar. At that time, the idea was for the Council to develop a model or mission to continue to self-correct other than contracting to privates or county commissioners.

Ann Schwindaman Rodriquez, Deputy Director of the NC Council of Community Programs, explained that a model had not been developed but that the Council has followed closely the work of the PCG. Area programs have been working together to pull together as a system. The Council has also been working very hard to establish a connection with the County Commissioners Association. One decision made by the Council is that things must remain local, that there cannot be only one statewide system. Therefore, the Council has somewhat built a relationship with county commissioners, and as a result of that, the Council is being extremely cautious about the way in which it approaches what the PCG and the State Auditor are proposing. There is definitely something to be said about maintaining a relationship with the county. The Council has not actually taken a strong position because results and recommendations are not final. Some of the areas, the Eastern region, Smoky Mountain and Blue Ridge, Wayne, Lenoir and Duplin-Sampson are all doing some very good work in doing exactly what PCG may be trying to do, that you do not have to dismantle a system.

June Cummings, Area Director, Lenoir Area Program, explained that one of the things being done through Lenoir, Wayne, and Duplin-Sampson is taking some natural alliances and developing those in a stronger way. There has been strong leadership from the area boards, particularly from board members who are county commissioners, in the development of this alliance. Recognition of the need for these natural alliances and the funding to phase in changes that need to take place is what the objective is. Duplin-Sampson, Lenoir and Wayne will take its proposal or plan for the development of a broader system to the Division within a week, and ask for support to move forward. These programs feel that what they have done is a model that will lend itself to both plans heard from the Division and the State Auditor's study. There is a need to move with flexibility with these natural alliances.

Dr. Whitaker reiterated that the point was raised in order to enlighten members and others that there is a great deal of support in the field.

Mrs. Moore called for the question. She asked for a vote. It passed unanimously.

She referred back to the motion, which was the letter to the Governor and copying the State Auditor, etc. opposing the County Commissioner model, and asked for a show of hands. The motion passed unanimously.

Floyd McCullouch, member, raised concern about the Developmental Disabilities Services Section being split from the Division as a separate Division, and what impact this would have on client services in mental health and substance abuse regarding funding. Tara Larson explained that there had been several interviews with Division staff. Information has been submitted from staff of the Division, as well as information provided by area programs.

Dr. Fisher acknowledged Commission staff for their work in preparing and carrying out the meetings.

Mrs. Moore thanked staff for returning to meeting and providing responses to Commission concerns.

Mrs. Moore also informed those members who terms expire in 2000 to contact the Governor's office for reappointment. Ms. Moore requested updates at the next meeting on the Performance Agreements and Utilization Review. She thanked Dr. Stelle, Charlotte and Marilyn for all their assistance with the meeting.

The next meeting of the Commission will be held on May 8-9, 2000 (since the February meeting, location for the May meeting will be at the Brownstone Hotel, Hillsborough Street, Raleigh, NC – telephone number for reservations is 1-800-331-7919).

Mrs. Moore adjourned the meeting.

Respectfully Submitted,

Charlotte F. Hall, Staff